PRINTED: 09/28/2010 FORM APPROVED Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS436AGC 08/24/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3980 PLACITA AVENUE QUALITY GUEST HOME 2** LAS VEGAS, NV 89121 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 000 Y 000 **Initial Comments** The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 8/24/10 State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for five Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness. The census at the time of the survey was five. Five resident files were reviewed and three employee files were reviewed. One discharged resident file was reviewed. The facility received a grade of A. The following deficiencies were identified: Y 178 449.209(5) Health and Sanitation-Maintain Int/Ext Y 178 SS=D NAC 449.209 5. The administrator of a residential facility shall

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

This Regulation is not met as evidenced by: Based on observation on 8/24/10, the facility

ensure that the premises are clean and that the interior, exterior and landscaping of the facility are

well maintained.

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Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
NVS436AGC			B. WING		08/24/2010		
NAME OF PROVIDER OR SUPPLIER			STREET ADD	<b>I</b> RESS, CITY, STA	TE, ZIP CODE		24/2010
QUALITY GUEST HOME 2			3980 PLACITA AVENUE LAS VEGAS, NV 89121				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATIO			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
Y 178	failed to ensure the premiss were clean and well maintained (the kitchen trash can full of food was uncovered, the emergency light in the hallway was not operational and the light switch in the back hallway was not operational).			Y 178			
	Severity: 2 Scope:	1					
Y 272 SS=C	Y 272 SS=C 449.2175(3) Service of Food - Menus			Y 272			
	NAC 449.2175 3. Menus must be in writing, planned a week in advance, dated, posted and kept on file for 90 days.						
	This Regulation is not met as evidenced by: Based on observation and interview on 8/24/10, the facility failed to ensure a planned, dated and posted menu was utilized.						
	Severity: 1 Scope: 3						
Y 885 SS=D	449.2742(9) Medication / Destruction			Y 885			
	the expiration date of has passed, or a residischarged from the finedication, an employed shall destroy the medication witness and note the medication in the reconstruction in the reconstruction was also as a second of the medication in the reconstruction was also as a second of the medication in the reconstruction was also as a second of the medication in the reconstruction was a second of the medication in the reconstruction was a second of the medication	facility does not claim the pyee of a residential factification, by an acceptate, in the presence of a destruction of the ord maintained pursuar hing contents of vials, iners into a toilet shall be	sident ne ility ole				

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FORM APPROVED Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS436AGC 08/24/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3980 PLACITA AVENUE QUALITY GUEST HOME 2** LAS VEGAS, NV 89121 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 885 Continued From page 2 Y 885 destruction of medication. This Regulation is not met as evidenced by: Based on observation and interview on 8/24/10, the facility failed to destroy medications after they were discontinued, had expired or after a resident had been transferred (Resident #6). This was a repeat deficiency from the 7/28/09 State Licensure survey. Severity: 2 Scope: 1 Y 936 Y 936 449.2749(1)(e) Resident file-NRS 441A SS=D Tuberculosis NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. This Regulation is not met as evidenced by:

Based on record review on 8/24/10, the facility failed to ensure 1 of 5 residents complied with NAC 441A.380 regarding tuberculosis testing (Resident #2 - no evidence of a positive

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Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING \_ NVS436AGC 08/24/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3980 PLACITA AVENUE **QUALITY GUEST HOME 2** LAS VEGAS, NV 89121 (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Y 936 Continued From page 3 Y 936 tuberculosis test). Severity: 2 Scope: 1

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